Peter Goodwin:

Good day and welcome to the Josiah Macy Jr. Foundation's webinar series, Barriers and Belief Systems. Today's webinar focuses on addressing disability accommodations and inclusion through a DEI lens. I'm Peter Goodwin, Chief Operating Officer and Treasurer at the Josiah Macy Jr. Foundation. Before we get started, a few housekeeping items. This session is being recorded. The audio, video, transcript as well as the Pretender slides will be available next week on the foundation's website at www.macyfoundation.org. We have live closed captioning for today's webinar. Please select the show captioning from your Zoom screen toolbar.

If you are having problems accessing these services, you can enter it into the Q&A function on your Zoom screen and a staff member will help you. The chat function on your Zoom screen is currently disabled and will be throughout the webinar. The Q&A function however, on your Zoom screen is active and will be throughout the webinar. Please use it to pose questions to the panelists that relate to the content of today's webinar. And now I'm pleased to introduce the President of the Josiah Macy Jr. Foundation, Dr. Holly Humphrey. Holly?

Holly J. Humphrey, MD, MACP:

Thank you, Peter. I am really thrilled to welcome all of you to today's webinar, specifically all of our panelists and our attendees. I am joined right now by Dr. Brigit Carter. Dr. Carter is the Chief Diversity Equity and Inclusion Officer at the American Association of Colleges of Nursing. She will be moderating today's panel discussion, but before I turn this over to her, I want to thank those who have helped us put together today's webinar and from whom you are going to have a chance to hear directly. I specifically want to thank the American Association of Colleges of Nursing, Docs with Disabilities Initiative and Johns Hopkins University Disability Health Research Center for their partnership with the Josiah Macy Jr. Foundation on this initiative.

Now, to put this whole webinar in context, I wanted to mention the three areas of health professions education that the Macy Foundation focuses on, and to give you a little bit of the background for how this webinar series came to be. So this particular series of webinars began in 2022 when we hosted three webinars on the barriers to inclusion for medical students, trainees and physicians, nurses being the lifeline of the healthcare system face unique challenges in education and practice. And so we want to highlight some of the solutions to these challenges through this webinar series.

The webinars are just one way in which the Macy Foundation is supporting the inclusion of students and nurses with disabilities by elevating their stories. Each webinar is informed by and includes people with disabilities. The Macy Foundation believes that disability is an important part of nursing's greater commitment to diversity, equity, and inclusion, and we invite you to engage with the multitude of resources available on the topic of disability inclusion in nursing, many of which are included on the resource list, which will be available after this series. We are all responsible for disability access and inclusion, and each of us must do our part to change the landscape and importantly, the mindset from one of exclusion and deficit to one that truly embraces and celebrates the talents of our colleagues and of our patients with disability.

I am especially excited to share a highlight that happened actually earlier this week in an announcement that was made by the National Institutes of Health. As some of you know, the National Institutes of Health has funded research on health inequities that are faced by racial, gender and other underserved communities. But one notable group that has historically been left out are people with disabilities. And so today, in a major victory for disability health advocates, the NIH announced that it has designated

people with disabilities as a health disparity population. This term, which is used to describe a disadvantaged group that experiences preventable differences in health will now dramatically expand access to funding and resources for studying and for helping disabled populations. I think you know that the NIH is the largest single public funder of biomedical research in the world. And so I think it goes without saying that this kind of inclusion by the NIH will have a dramatic impact on our ability to gain a better understanding of disability and how we can include those patients and our healthcare providers in this important work.

Disability advocates say that the change reflects an ongoing shift in medicine from trying to fix or cure disabled people toward viewing them more holistically as a demographic group with its own unique challenges. Thank you to all of the health equity champions who came together to facilitate this change. I would specifically like to highlight and thank Dr. Bonnie Swenor, a co-developer of this series and her colleague, Jay Kennedy, who showed exceptional leadership in these efforts.

And now it is my absolute pleasure to turn this webinar over to our distinguished moderator, Dr. Brigit Carter and our panelists, Dr. Amber Kimball Hsu, Ms. Emily Magee, Dr. Liz Madigan and Dr. Lisa Meeks. Dr. Carter is the Chief Diversity, Equity and Inclusion Officer at the American Association of Colleges of Nursing. Dr. Hsu is the Clinical Policy Nurse Consultant at the North Carolina Department of Health and Human Services, and I'd like to invite her to turn on her camera so that we can all welcome her to today's webinar.

Dr. Madigan is Chief Executive Officer of Sigma Theta Tau International Honor Society of Nursing, and I'd like to invite her to turn on her camera. Dr. Madigan is already introduced by me. Dr. Magee is Director of Student Disability Services at Eastern Virginia Medical School. I'd like to invite her to turn on her camera, and Dr. Meeks, I know is well known to our webinar audiences as the fearless leader of the work that the Macy Foundation has engaged related to this topic. And Dr. Meeks is the Associate Professor of Learning Health Sciences and Family Medicine at the University of Michigan Medical School and co-creator of the social media campaign #docswithdisabilities, co-host of the Docs with Disabilities podcast and Executive Director of the Docs with Disabilities Initiative. And so now that I've introduced all of our distinguished panelists who I know you're going to learn a lot from today, I'd like to turn things over to our moderator, Dr. Brigit Carter. Brigit, take it away.

Brigit Carter, PhD, RN, CCRN, FAAN:

Thank you so much, Dr. Humphrey. It is indeed my honor to be here today and to be a part of this very important webinar. And I really just want to start by saying these two words, inclusion matters. When we use the words diversity, equity, inclusion and belonging, we are speaking to an extremely broad and a powerful audience of individuals who have many differing characteristics that make them unique and how they contribute to our beautiful tapestry of our community. So it is just as key for a patient of racial or ethnic diversity to see a nurse that shares their racial or ethnic heritage, as it is for a patient with a disability to see a nurse with a disability.

There is really so much added value when we integrate people with a unique view of the world, and it also increases our ability to solve challenging healthcare issues that are specifically relevant to that group. And when we say inclusion, it means that we recognize, that we welcome, that we support and value the talents of what individuals can bring to the organization's community. Inclusion has to be done with intention, authenticity and respect. Therefore, we shouldn't approach disability with this ableist attitude, but with an attitude of wonder and curiosity about how this student can be supported to achieve their goal of becoming a professional nurse.

In this webinar, we're going to address how to determine reasonable accommodations, what are some of the common accommodations in nursing education and training and outline the faculty role in the process of determining and implementing accommodations. So we have some objectives that we are going to be looking at to begin our talk. So we hope to have you leave this space understanding how to align some of the DEI principles with disability inclusion, that you understand the process for determining reasonable accommodations in nursing education and training. Leave with some examples of reasonable accommodations and nursing education and training, and then also being able to recognize what the role of faculty and team members are, like our disability resource persons in the accommodations process.

And so now I am going to turn this over for Dr. Meeks to get us started. Lisa?

Lisa Meeks, PhD, MA:

Thanks so much, Dr. Carter. As in previous webinars, we want to give you an overview of the main resources that were used for this webinar. The Disability as Diversity book is available via most academic library systems. The Equal Access for Students With Disabilities book is now available as a free download, and those links are going to be put into the communication, the chat for you right now. And the AAMC, Accessibility, Inclusion and Action in Medical Education report is also available for free download. So all three links are being added to your chat and they're going to be listed in the toolkit as well. I want to point out that there are a myriad of resources available. All of these will be listed in that toolkit we've been talking about throughout the series and will be posted to the Macy website in the same space that you found the registration for this webinar within the week.

So as Dr. Carter said, if you want to go to next slide, the disability group, people with disabilities are a really, really important group. Currently, 26.8 or thereabouts percent of the US population includes people with disabilities. So let's break that down a little bit more. It's about one in four people. So if we think about the 1,400 people who registered for this webinar, about 350 of them would have lived experience of disability. And remember that most disabilities are non-apparent, so you are going to have no indication that that individual is living with disability or has experienced disability, but at some point in their lives, this is going to represent the patients that we serve. So about one in four of the patients that we serve, that we see, that we're helping to thrive are going to be people with disabilities. Well, when you think about it in that context, lacking an understanding of disability is unacceptable, and we must do better.

As you learned in previous webinars here in this series, ableism and the accompanying stereotypes and perceptions that are formed with ableism that drive many of the barriers to equal access is a major part of the issue. We believe that the inclusion of people with disabilities in the healthcare workforce is one, just one, but a powerful way to combat much of the ableism. By including qualified nurses with disabilities in the healthcare system, we begin to dismantle the belief systems about disability, about what it means to be disabled, and we open the door to improving healthcare for patients with disabilities. Here to tell you more about being a nurse with a disability is Dr. Amber Hsu.

Amber Kimball Hsu, PhD, RN:

Hi, I'm Amber and I'm honored to be here on this panel today with these wonderful leaders in the nursing and disability space. I'm bilaterally, profoundly deaf with a unilateral cochlear implant and I'm a nurse. I feel fortunate to have delivered varied types of nursing care through clinical research, education, and policy. This very professional experience coupled with my personal experience as an

individual with a disability has given me a kaleidoscope type lens on the intersection of disability and healthcare.

As a deaf person entering nursing, I knew it would be challenging. However, I was relatively naive to the types and intensity of the challenges that awaited me. Initially, I focused heavily on obtaining supplies and ensuring that I could use them well to be successful in nursing school, such as an amplified stethoscope. Soon after starting nursing school, that focus shifted from completing my skills well to past competency, to completing my skills well to prove that I was able to do it despite my disability.

One instance in particular was striking and it is still recalled to this day. 10 years later, my classmates who were in the same room. I was in the first semester of second year of the associate's degree and nursing program, and we had physical assessment checkoffs. These checkoffs had one instructor per room with four groups of students and two students in each group, so eight students total. All four groups were conducting their physical assessments at the same time with one student acting as a patient and the other as a nurse. And the one instructor rotated periodically, making her rounds at each group. We were told that we would not have to do everything in order so long as we did everything on the assessment checkoff, we would pass.

My partner, an LPN bridge student went first as the nurse. The instructor visited our group a few times in short stints grading my partner skills. Although my partner actually missed a few steps, including listening to gastric sounds, they passed. When it was time to switch, the instructor saw my amplified stethoscope on the bedside table and beelined for a group and remained there for the entire duration of the assessment, periodically watching other groups from that spot.

Because I was still learning how to seamlessly integrate the stethoscope into my physical assessment due to extra steps like changing the setting of my cochlear implant, I opted to wait to use the stethoscope until the end of the assessment. Again, we didn't have to do things in order, and when I told her why I was waiting until the end, she said I needed to follow the assessment as it was written. The instructor then said that my stethoscope was not approved for facility or school use. I responded that I had gained approval from the director of the program prior to starting the program a year ago. The instructor wouldn't budge and immediately recommended me for remediation despite never assessing my skills.

But in remediation, something great happened. I had a nursing instructor who had lost some of her hearing later in life, and she made it a point to support me with regard to navigating the program, including clinicals. She graded my physical assessment the next day without concern for my adaptive stethoscope, and I passed. While one person presented with ableist and restrictive views of my ability before I was even allowed to show my skills, the other with lived experience was able to remove any notion of what it means to have hearing loss and support me and assess me without bias.

I've been fortunate to have had that experience and to have worked with and encountered amazing people within the nursing and disability space who believed that a deaf nurse is a valuable asset to healthcare. As Dr. Meeks pointed out, more education about disability inclusion and sharing more stories of nurses with disabilities will help to create a more diverse, accessible environment where all nurses can thrive. And now I'll turn it over to Emily Magee to tell you more about how decisions are made.

Emily Magee, MEd, MS:

Thank you, Amber. Determining reasonable clinical accommodations and health science programs is a highly nuanced process that requires an advanced understanding of health professions education,

assistive technology, knowledge of safely modified procedural approaches and a solid knowledge of the legal requirements for reasonable accommodation under the Americans with Disabilities Act.

So what is a reasonable accommodation? Well, reasonable accommodations are generally considered to be anything that is possible that does not constitute a financial hardship for the institution or fundamentally alter the nature of a program. While discussing fundamental alteration, I also want to address patient safety as a concern by highlighting that this is almost actually never an issue. If you'd like to learn more about this topic, I would encourage you to check out the newly free book, Equal Access for Students with Disabilities: The Guide for Health Science and Professional Education by Meeks, Jane and Laird, that does a deep dive into what constitutes a patient safety concern. You've already been provided this link in the chat.

So how do programs decide what is reasonable? To determine whether a request is reasonable, institutions appoint a representative to serve as a facilitator of the interactive process. This role is often titled the Disability resource Professional, DRP, the term we will use today. This person oversees the interactive process, collects documentation from the student regarding the disability, works with institutional and clinical stakeholders, nursing faculty and coordinators like many in today's audience. And if needed, external stakeholders such as other institutions, OCR, consultants and legal counsel.

Next slide, please. The decision-making about reasonable accommodations occurs through what we call an interactive process. This process includes the student, the representatives from the institution, including the disability resource professional, and the faculty. This diagram below or shown on your screen rather, outlines the six steps in the interactive process and is included in the AAMC report. To get us started on this process, I'll hand it over to Dr. Madigan.

Liz Madigan, PhD, RN, FAAN:

Thank you, Emily. As you can see from this colorful wheel that outlines the process, the first step is really on the program. The program must clearly define its curriculum and its essential functions. When these are codified and easily communicated to the DRP and the student, it makes it easier to begin a thoughtful informed process. In step two, the program faculty, the DRP and the student review the required items to determine if there are any barriers.

Now, an important step for this is recognizing that the student has never been a nursing student before in most cases. This presents a bit of an issue as they will not be fully aware of their needs nor the barriers. For this reason, it is essential for faculty and the DRP to be true partners in this space, even to have the DRP rotate with their nursing faculty to see what it's truly like in the various clinical settings, and to see the physical, technical, and cognitive skills required for nursing practice.

To help the DRP and student engage in a robust interactive process, the program and faculty should have a competency checklist for each course that you teach that communicates the what of an educational experience, including what the student must know, what information must be translated into practice, what information needs to be translated into a performance standard or procedural standard, and what information just needs to be observed? Your competency checklist should be clear, concise, and measurable.

And finally, you must be able to map a competency onto actual practice or accreditation requirements for your program. Okay, now let's look at the next few steps with Emily.

Emily Magee, MEd, MS:

As Dr. Madigan stated, the outcomes are always better when the interactive process is addressed as a team. DRPs and faculty have the same goals, equal access and diversity within safe and effective practice for graduation and licensure. A seasoned DRP will have a good command of the program's technical standards and maintain partnerships with program directors, clinical rotation directors, and clinical coordinators. Ideally, DRPs will visit clinical sites to gain firsthand knowledge of potential barriers that exist for students with specific functional limitations.

While we cannot teach all of these specialized skills today, we've provided a handout from Dr. Meeks' book, Disability as Diversity. This handout titled Clinical Accommodation Program Inquiry provides questions for DRPs to utilize for building their knowledge base about campus health science programs, which in conjunction with the free book I mentioned earlier, will assist DRPs and faculty alike in becoming more specialized to develop specialized knowledge in clinical accommodations, assistive devices, case law, progressive practices and the use of simulation, Lisa's favorite topic.

Okay, the next step is for the DRP. To develop an accommodation plan. You must ensure that any proposed accommodation is not a fundamental alteration of the program. Thinking back to step one in determining whether an accommodation presents a fundamental alteration, the DRP will be looking at your syllabus as a source of important information. Remember, disability offices do not want to challenge the rigor of your program, change your learning outcomes, or reduce the competencies. They want to work with you in partnership.

Step four. Step four reminds us that the accommodations are recommendations only. The student may have ideas based on their lived experience about what version of accommodations or accommodation option may work best for them. This is an important step. The student is always an expert on their disability. Remember, disabilities, even those that carry the same diagnosis, affect people very differently based on a myriad of background experiences, access to resources and interventions and cultural/educational experiences. We must always remember that our students are unique individuals and that all disability accommodation review is individualized. Just because an accommodation is effective for one student does not mean it will be for all.

Dr. Madigan will tell you about the next step, something that requires a robust collaboration with faculty and program leaders.

Liz Madigan, PhD, RN, FAAN:

Thanks, Emily. We are now back to the faculty DRP leadership portion of the interactive process in step five. Once the discussion has occurred with the student and the DRP has a sense of the most effective accommodation, we do a final check to see if there is any undue administrative or financial burden on the school. The last question is, would the proposed accommodation cause an undue burden on the school? This argument is almost never successful. As an example, the courts determine that in the Argenyi versus Creighton case, an excess of $200,000 was not considered burdensome for a CART and interpreters. Similarly, in Featherstone versus Northwest University, a CART and interpreters were not considered an undue burden. In fact, in about 99.9% of cases, undue burden will not be something that you can use to deny accommodation.

And when determining whether an accommodation is an undue financial barrier, the courts will look at the entire operating budget of the institution, not just your academic program. While Emily will tell you more about the final step, I hope you are beginning to realize and recognize how vitally important it is to work together as a team in the interactive process. Emily?

Emily Magee, MEd, MS:

Step six is the feedback loop that we all know is critically important. While we determine an accommodation and implemented it, this is not an exact science. We need to check in to make sure that disability related barrier is removed and do an assessment of whether the student is now able to show us what they know. This may include gathering data points about performance improvement from faculty and self-report access from the student. The faculty will be the first to recognize that the student is still struggling, so close collaboration is needed.

Now, I cannot say this strongly enough. It is never okay to have a blanket statement that suggests that accommodations in clinical rotations or in clinical assessments do not occur. The law requires you to undergo an interactive process and to make a good faith effort to find a reasonable accommodation for the student. To uniformly say no is not in keeping with the law.

Liz Madigan, PhD, RN, FAAN:

Thank you, Emily, for so nicely delineating the accommodation decision process. It's important to recognize the role of faculty in the accommodation process. I want to briefly review some important considerations. This includes conflicts of interest. While faculty are important to the interactive process and informing accommodation decisions, individuals who hold an evaluative role or who serve in the role of admissions or student affairs as a Dean or Director of a program should not review confidential disability documentation as part of this process.

Indeed, the DRP serves in this part of the process. That is they review the documentation and determine functional limitations and barriers. Then they communicate this to the faculty as needed with the disability related barriers leading the conversation versus a diagnosis. Then the faculty assists the DRP in understanding the program's essential functions and structure. Together, they develop accommodation ideas and when accommodations have been requested, they review the reasonable nature of the student's request.

Managing your varied roles is important. Nurses are incredibly giving and caring people, and we are often deeply involved with our students and mentoring them with all aspects of their life. It's important, however, to remember that not everyone wishes to share information about their disability with their instructors. You should never ask directly about disability identity. If you find yourself using your clinical skills, stop. This is where faculty sometimes cross the line into the role of the DRP. The landscape for disabilities and accommodations are constantly changing. Faculty are not sufficiently knowledgeable of ADA, case law and accommodations. Making a mistake here has real implications for the institution.

Similarly, faculty should not pass accommodation requests along to other faculty as students transition from course to course and level to level. Students who need accommodations in one course may not need accommodations for a subsequent course, and passing along the information to another faculty member in another course is not appropriate. Remember that some students feel shame and embarrassment about their need for accommodations. Faculty responses with verbally and non-verbally should be sensitive to this possibility.

A matter of fact response here is your best kind of response. Nurses have a long-standing commitment to social justice, particularly equity. We have used our commitment to social justice for many years to better the lives of those we care for in a clinical encounter. The same commitment to equity needs to occur with our students and colleagues who also have a disability. Dr. Meeks?

Lisa Meeks, PhD, MA:

Yeah. Thank you so much, Emily and Dr. Madigan for describing the process. And thank you, Dr. Madigan for pointing out the need to really normalize this as something that happens in nursing education and to make sure that you're not shaming the student or causing them to have any embarrassment because of their request for accommodation. You'll notice that in none of this, we mentioned the student's diagnosis. It's actually not part of the interactive process, which you may find interesting, but this is an important fact and not one that's well understood.

Let's think about three diagnoses here. If we were making a decision based on diagnosis, we'd be assuming a lot about the diagnosis, how it's expressed, how it results in difficulty for the student. But in many cases, the diagnosis won't tell us anything about how the student is feeling or functioning, the effects of their condition. And this may be very different across varied situations. So as an example, ADHD, depression and autoimmune disorder may present very differently in different students, and it may also depend on environmental factors like weather, high stress periods, or when students are switching from days to nights.

So how do we make these decisions? Well, instead, accommodation decisions are focused on functional impairment, so students with totally different diagnoses may actually share similar symptoms and similar functional impairment. To determine the need for accommodation, the institution or the program must review the student's functional limitations, that is the restrictions that prevent them from fully performing the activity, the activity that is serving as a barrier, and then the core competencies of the program, as you heard from Dr. Madigan.

And so reasonable accommodations are really what we use to serve as a mechanism for removing these barriers. As you can see in this Venn diagram on this slide, there's an overlap between the three diagnoses I just mentioned, ADHD, autoimmune disorders and depression. Even though these are different diagnoses, they share some similar symptoms and may lead to similar functional limitations like difficulty focusing, slowed processing, lethargy or the need for weekly appointments. To address this, the same or a similar accommodation may be needed despite having different diagnoses.

So let's look at some of the common accommodations that we see in nursing programs. Well, as we were just discussing, some students may present with slowed processing or may have a reading based disability. In these cases, it's been found nationally to be reasonable to provide additional time on exams in OSCEs or clinical assessments, or to have the use of a screen reader in the wards to review patient charts.

Now, that's probably not going to surprise you. Another example, physical access barriers in the clinic. So some things that have been found to be reasonable include automatic doors, lowering physical exam tools, adjustable tables, accessible charting stations. And again, this is probably not new to you and probably not setting up any concern about the reasonable nature of these accommodations. For students that are deaf or hard of hearing, ASL interpreters, captioning and queued speech are all determined throughout the nation and across the courts have all been determined to be reasonable accommodations that do not fundamentally alter or cause any patient safety concerns.

So this is a reasonable accommodation. For students who have low vision and accessible charting station, the use of surgical loops or magnifying devices have also been found to be reasonable. And then disability impacted by sleep disruption or deregulation is something that we address proactively. So we might assign the student to have continuity and whether they're doing days or nights. So perhaps it's no night float assignment, or in some cases we allow for additional days in-between the switching from days to nights to re-regulate the system. All of these examples are typical accommodations that the courts have found to be reasonable in nursing programs. And I'm going to turn it back over to Amber.

Amber Kimball Hsu, PhD, RN:

[inaudible 00:35:36] discussed the process for working together to develop an accommodations plan. While Lisa talked about accommodations that will create access for our nursing students, I offer the next level. While access is important and critical to training more nurses, inclusion of these nurses will not automatically come with accommodations or additional time on tests. Inclusion is part of the community sphere and ethos where nurses with disabilities feel safe, respected, and appreciated. We also need to broaden our ideas about what a nurse does. Although most nurses are in the clinical sector, it is critical to have nurses conduct research, formulate policies, and educate others to ensure optimal healthcare delivery. These are critical roles that shape public health and health policy. Regardless of where nurses find their place, ensuring a diverse nursing workforce is important to the delivery of health care services and patient experiences. Patients are getting older, sicker, and encountering more disability, yet they still navigate a role that isn't always accessible or inclusive of disability, which can be stressful and disorienting.

As a nurse with a disability, I have found that I am privy to recognizing challenges and access to care for patients with disabilities, and identifying resources and solutions that can often meet the needs of the patients while still understanding the organization's limitations. I have also found that the accommodations I may request in the workplace for myself often benefit others who may not know that these accommodations exist or I may be too afraid to ask for them. Creating a diverse nursing workforce that includes nurses with disabilities can only make for a stronger profession and subsequently improved healthcare delivery. Limiting individuals with disabilities equitable access to proper nursing education by unfair gatekeeping is doing a disservice not only to the individual, but to the nursing profession and society at large. Now I'll turn it back over to Dr. Carter.

Brigit Carter, PhD, RN, CCRN, FAAN:

Thank you, Dr. Hsu, and thank you to all of our panelists. This has been a wonderful discussion for your insight, your reflection, and also Dr. Hsu, as a nurse with a disability. This is just incredible expertise and guidance. We also want to thank you our audience for participating. This is just the first step in helping to create more accessible training programs for future generations of nurses with disabilities. So we do want to tell you how to access the toolkit and the free CEU credits through AACN. The toolkit will be posted to the same site as the previous webinar recordings, which are being placed in the chat right now. All evaluations and continuing education units will be found on the AACN webpage, and that will be posted at the conclusion of this webinar. So each recorded webinar will require completed evaluation and a certificate for CEU will be provided after you submit the evaluation. You earn one credit per webinar for a total of three CEUs. And if you have any further questions, feel free to reach out to our ACN staff member, Cassie, and we will put her email in the chat as well.

And we also want to encourage you to review the first two webinars. And as you can see, the address on this slide is where the webinar series can be found for questions about the series or questions just in general, please do feel free to email info@macyfoundation.org. And if you do not have the Equal Access book, it is now available, and I'm going to say free because it's a free download at www.docswithdisabilities.org.

So now we're going to move to our question... I'm going to stop sharing. We're going to move to our question and answer portion and we ask that you would please put any questions that you have in the question section and we will go through these and hopefully provide some valuable information as we move forward. And again, there's questions that we will answer directly. So we had a question that I

thought was really good about memory aids. So someone was curious about memory aids for someone with TBI especially in lab work. Do we have any thoughts about that?

Emily Magee, MEd, MS:

I can jump in on that one.

Brigit Carter, PhD, RN, CCRN, FAAN:

All right, Emily.

Emily Magee, MEd, MS:

I love a checklist and if a student is able to, whether they are carrying around a clipboard with them, going into a standardized patient assessment, to where that list of all of those required steps that they will need to do can be listed out on there. So a student has that visual reminder and they maybe not sure if they checked something off, they can always look to and reference and reference that checklist, and I think that's a great resource for a student particularly with a memory challenge.

Brigit Carter, PhD, RN, CCRN, FAAN:

Thank you so much Emily. We have some wonderful questions here. Our next question, and please anyone feel free to answer, "We tell the student that accommodations must be approved through the clinical site. Is that a problem?"

Lisa Meeks, PhD, MA:

Yes, that's a problem. Don't fret, but I do want to provide some context around it. The way the courts view your program is that it is your program. The student is paying you the tuition, so you are the responsible party. Any training site that you employ or have a contract with to help in that training process is merely an extension of your program. You are responsible essentially for accommodation and equitable access in that setting.

So in these circumstances, allowing the student or having the student go and negotiate on their own behalf is actually something that the courts are going to frown on. That is not best practice, nor would it be in your favor if a complaint was made. There are some Office of Civil Rights cases that point to this. They are included in that equal access book. And to allow us more time to get all of these, I see the questions coming in, I will end there, but please know that this is something you should definitely follow up on. It is definitely something the book covers as well. So I feel like you're being left in really good hands there.

Brigit Carter, PhD, RN, CCRN, FAAN:

Thank you so much, Dr. Meeks. Another question. This person is the designated DRP at their campus and there is currently something in the application stating that students share with the Dean of the Nursing Program in our office. This person doesn't feel this is acceptable and they need legal verbiage to show them that what we are currently doing is not okay. So where can this person find that type of information?

Lisa Meeks, PhD, MA:

Emily, I'm trying not to be the person talking all the time.

Emily Magee, MEd, MS:

Would you take this one though?

Lisa Meeks, PhD, MA:

Yeah, sure. It's also in the book. There's clear guidance from OCR when a Dean of a program is the sole... Not the sole, but when the Dean of a program gets involved. In this particular instance, it's a resolution letter, which is a letter that gets sent by the Office of Civil Rights when an institution that has had a complaint filed against them decides to cooperate and make changes that would keep them in compliance with the law. And so the particular OCR resolution letter I would point you to is... And I'm sorry, University of Florida, but it's a University of Florida School of Medicine letter where the Dean became intimately involved, communicating with the learner outside of communication with the disability office. And that became highly problematic and there was some restitution that had to happen for the student by the program because of that communication.

And I think what comes out of that resolution letter in particular is just highlighting that the Dean of a program does not have the nuanced understanding of the law or clinical accommodations. There's also some additional guidance in there about cases where it has been shown or the courts have said, or OCR has said that the person overseeing the program should not be the individual taking the disclosure of disability accommodation. So that dual reporting system that you have set up in your school, I'm glad, I'm so glad as a DRP that you've highlighted this as being problematic. You will be able to find everything I'm talking about in the book and you can take that to your Dean.

And really for your Dean, they don't want the disclosure to go to them because when you're talking about the potential for a complaint that someone has been discriminated against. If the Dean is not aware of the situation, they can hardly discriminate. Right? So making sure that we keep individual student information very much situated in the disability office, and we don't even need to bring up student names when we have conversations going through the interactive process either. So that can be anonymized as well until we're implementing accommodations. So that would be my response.

Brigit Carter, PhD, RN, CCRN, FAAN:

Thank you so much again, Dr. Meeks. So now to an accommodation question, "Could it be reasonable to allow a student with a lifting restriction to participate in a clinic setting? We've had a student denied access to a class because a clinic site would not allow the student to be placed."

Emily Magee, MEd, MS:

I'll take that one. So I would say it depends and really, you have to go to the... There's the difference obviously between a fundamental alteration and something that is required as part of the curriculum, but also thinking a bit more broadly of there are a lot of lifting aids that can be used in that clinical setting. So I think it is really important to be thinking about also, not necessarily just the how, but if the student would be able to use an accommodation to allow them to safely be able to lift or to move a patient.

Brigit Carter, PhD, RN, CCRN, FAAN:

Thank you so much Emily.

Lisa Meeks, PhD, MA:

And I would just add that if you're going to have a... First of all, I guess my problem begins with having a lifting requirement because there's so many policies in place for bedside nurses to protect nurses from getting harmed by having protocol that speak to doing dual lifts or using a Hoyer lift or using some sort of technique that would keep them from getting harmed. And so making sure that if you do have a lifting requirement in your program, that you are uniformly applying that to all students. Again, discrimination is essentially disparate treatment.

So if you are saying based on your visual assessment of a student or their self-report that the student wouldn't meet the lifting requirements, how are you assessing every other student to make sure that they are also meeting the lifting requirements? And I say, do we line them up and put a 50 pound dumbbell in and have everyone do this? So we just need to make sure that if you have a requirement that you are assessing it uniformly without bias, that it is fundamental to the practice of nursing and that you can defend it.

Brigit Carter, PhD, RN, CCRN, FAAN:

Thank you, Dr. Meeks. More questions around accommodations. Someone is curious about your thoughts on flexible classroom attendance? They have some students who receive this but tend not to come to class except for examinations. They give them a recording of the lecture and so they just want to know your thoughts on this and how do you prepare them for the workforce when you need to attend work and show up on time?

Emily Magee, MEd, MS:

I would say it is not appropriate to miss every class, and that is why typically attendance based accommodations similarly to extension or flexibility with assignment accommodations are handled on a case by case basis, as well as really identifying what is that barrier that is preventing the student from coming to class? Because is there a change that the student may need to make? Is it because they may need to adjust their schedule to where in order to take care of their own personal disability related needs that they may have to be up a bit earlier so that they're able to tend to those needs so that they can attend class.

If a student were to need to miss every class but they can make it to every exam, I do believe that that would require a much further conversation of how is that barrier manifesting? And if it is every single class that they need to miss, then again, I think that larger conversation of what is that barrier and do you need to maybe take some time?

If you need to miss every class, then that would be probably a serious issue that's going on. So again, I think that handling it on that case by case basis is really important. And then really drilling into what that barrier is and can we provide other supports or other resources so that a student is able to tend to those disability related needs and still be attending class and getting all of the knowledge that they need because there is so much that is happening in that classroom setting.

Brigit Carter, PhD, RN, CCRN, FAAN:

All right, thank you so very much. So there is a question around accommodations for psychomotor assessments. "What are your thoughts on extended time for physical assessment validation or medication checkoff? These occur in both the academic and clinical environment." Any thoughts on extended periods of time for those checkoffs?

Lisa Meeks, PhD, MA:

I will say that it's a highly nuanced decision that requires an understanding of whether the assessed version or the assessed portion of the clinical checkoff is a time dependent activity. So if it is time dependent, then certainly you are able to, and if there's a good justification for that time dependence, then you should have time as a function of the assessment. And that is we don't adjust for that if it's essential that something be conducted in a certain amount of time. If it is not time dependent, and I will say this out loud too often, we assign time to things where time is not a function, it's not an essential function really of this activity. So if time is not an essential function of the activity, and this gets back to Dr. Madigan talking about the need for the essential functions, the need to share these with your DRP. If it's not an essential part of that assessment, then you could produce or provides, sorry, extra time for the student.

So when we look at this in an OSCE, it may be that reading the door notes before you go in or writing up the case notes after you've seen the patient, really, time is not an essential function outside of our 10 or 15 minute model that we put into practice outside of the education system. But that the time with the patient, for whatever reason is solely dependent on time. There is some sort of necessity to finish this and a certain amount of time. If you can justify that, if you can ground that in your essential functions, then you can subscribe time and not provide the accommodation. And I think it's a lot more nuanced than I'm presenting here. So I hate to even answer the question, but it is a highly nuanced process. But I would say that it's not unheard of and in all cases, it's not unreasonable.

Brigit Carter, PhD, RN, CCRN, FAAN:

Thank you so much. So we have a brand new DRP in the audience and they're saying it's their role to communicate the hospital regarding any clinical accommodations. Well, that's the question. Is it their role to communicate with the hospital regarding any clinical accommodations or does the clinical coordinator do this? They see how the roles can collaborate together but would like some more advice?

Emily Magee, MEd, MS:

That's why those relationships are so critical, and building those connections with both the clerkship coordinators as well as those clerkship directors. I personally send them to both and we are very much collaborative so that everyone is aware of what the student's accommodations are. So while yes, that coordinator is critical, having that relationship with the clerkship directors and those preceptors is also very important.

Brigit Carter, PhD, RN, CCRN, FAAN:

Thank you so much. We have a few more minutes left. So there's a comment, not really a question, but I thought I posed this. "We're not concerned about accommodations for the students in context of our program boundaries. The challenge is seeking a clinical site that will be able to provide accommodations for our students. Mostly this is students with physical disabilities." And you may or may not want to comment on that, but I think that was something we wanted to bring forward. Any comments?

Lisa Meeks, PhD, MA:

My comment is what an amazing opportunity to show that you're an inclusive training environment and to learn about what your patients go through. And so I do think sometimes when we have these conversations, we actually do ourselves a disservice by communicating to the clinical site, "Oh, we have

the student, I'm so worried, are they going to be able to navigate your space?" Instead of coming into the conversation strong and saying, "Wow, this is an amazing opportunity for us to innovate, to think about how our patients navigate this space and to learn from someone who has the lived experience of being a wheelchair user. How can we do this together?" And really building that excitement and building that partnership, I think that's what's amazing.

And then having people like Dr. Madigan, who is a nurse leader and was a Department Chair, and having people like Amber Kimball Hsu, who can share their stories. And I think these stories are the most important takeaway, that if we have people like Dr. Madigan sharing stories of success that they've integrated at Case Western where they were chair or other places, and then people like Dr. Hsu sharing her story. I think that's the most powerful way to change the perception and the fear.

I would imagine that most people going into this, it's really fear-driven and that's understandable. You don't know what's going to happen. You don't know a lot about disability. We're not judging you for being in that space, but how can we take away that fear? How can we provide education and how can we use storytelling and experiences like this to really invite you to be brave in this space and to approach this with a can-do mindset and excitement and enthusiasm for diversifying the nursing workforce. I think that's where we need to be.

And I see 40 questions and my facial expressions, I'm a terrible poker... I must be like, but I think that that's where we need to move forward, to bring this back to the DEI perspective. I think when we start to shift Dr. Carter, like you said, to thinking about this as a diversity issue, then everything changes, right? That's what we want.

Brigit Carter, PhD, RN, CCRN, FAAN:

Thank you so much. We have time for just one last question. I'm going to give this to a student. This is a deaf nursing student and she was, "While they were aware of their diagnosis of deafness as a part of their own medical record, and I don't need to disclose that unless necessary. However, how can I as a nursing student ensure that the professors of the nursing program actually do not directly validate the HIPAA when discussing students in the program?"

Lisa Meeks, PhD, MA:

Amber, I think you're probably the best person.

Amber Kimball Hsu, PhD, RN:

So this is a great question. As a student, you're not really in that position to really know what the professors are saying behind closed doors. So it's really hard to be able to pinpoint what professors are talking about you and so on and so forth. And it's one of those things where with disclosing hearing loss or deafness, everyone has their own perspective on it. On a personal level, I like to disclose early and as often as possible with everyone I engage with. And this was a relatively new perspective that I had because when I was younger, up until I was about 21, 22, I did not disclose. And that significantly impacted my relationships with people because they wouldn't know that I had hearing loss. And so they would just feel like I was ignoring them, and I knew that it would be a safety issue for me to care for a patient or work with colleagues on the floor and not disclose my deafness and hearing loss. So that was my choice to do that.

And so I found that disclosing early and often, actually, it works better for me than not doing that. But yeah, as far as the professors go, I think like I said, it's going to be hard to gauge what conversations are being had. So I'm hoping that helps and I answered the question.

Lisa Meeks, PhD, MA:

Yes. Thank you so much, Dr. Hsu for your unique perspective on this, and we are going to turn this over to Dr. Humphrey to close us out. Thank you again to our panelists and participants. Dr. Humphrey?

Holly J. Humphrey, MD, MACP:

Well, thank you Dr. Carter, and a very big thanks to all of today's panelists. Not only did we all learn so much from your stories and your vast experience in this field, but we also learned from our audience with the questions that were being posed. And there are so many additional questions that we didn't get to today. But again, I want to thank all of you for what you brought to today's conversation and today's discussion.

I also want to let you know that the Macy Foundation is in active conversation with nursing leaders to explore more ways and new ways that the Macy Foundation can support disability inclusion in nursing. And so I encourage all of you to stay tuned for more information over the coming months. I hope we will have more to share with all of you.

I also want to extend a special thanks to our designated interpreters for captioning today and our prior webinars in the series. So thanks to all of you and let me turn it over to my colleague, Mr. Peter Goodwin.

Peter Goodwin:

Thank you, Holly, and thank you to our panelists and all of the attendees who joined us today for this webinar. To repeat some things that we've underscored, you can find prior webinars on disability on the Foundation's website, and that link has been put into the chat, but it's also at macyfoundation.org, where we invite you to sign up for periodic email alerts from us at the Foundation. Information about obtaining CEUs has also been put into the chat as well. So I would ask you to open up your chat box and you will find it there.

And if you have any questions about that, you may contact Cassie, whose email has been placed in the chat at the AACN. For any questions that we were able to take today during the webinar, feel free to contact us at info@macysfoundation.org and we will be printing out all of the questions we could not get to, and we'll be reviewing them and deciding on what next steps we might want to take.

Lastly, we encourage you after this webinar to continue the discussion tomorrow and after, online using hashtags, #equityinclinicallearning, #nursewithdisabilities and hashtags, docs with disabilities. Thank you all for participating with us today. Enjoy the rest of your day. Goodbye.